STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035086	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sierra Vista, LLC	660 South Coronado Drive Sierra Vista, AZ 85635

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035086	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sierra Vista, LLC	660 South Coronado Drive Sierra Vista, AZ 85635

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records and facility policies and procedures, the facility failed to ensure two out of two sampled resident's (#10 and #81) medications were protected from diversion by one staff (#201). The deficient practice could result in residents not receiving prescribed medications, placing them at risk for unmanaged pain, withdrawal symptoms or other adverse outcomes.Findings include:Related to Resident #10-Resident #10 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of vulva, rheumatoid arthritis, and chronic pain syndrome.Review of the change of condition Minimum Data Set (MDS), dated [DATE] revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. The MDS also revealed that she was receiving hospice care. Review of the physician's orders revealed an order for Oxycodone HCl (an Opioid analgesics) oral tablet 5 mg (milligrams) which was to be given to Resident #10 every 4 hours as needed for pain rating 6-10.Review of the care plan, initiated on October 20, 2025 revealed a goal of ensuring comfort care was provided due to her terminal illness and that she was receiving opioids. Interventions included administering medications as ordered to ensure resident's comfort and to document pain management.Related to Resident #81-Resident #81 was admitted to the facility on [DATE] with diagnoses of acute kidney failure, type 2 diabetes, and essential tremor.Review of the care plan, revised on July 12, 2024 revealed interventions to address her diabetes mellitus. Interventions included diabetes medications as ordered by the provider and monitoring side effects and effectiveness.Review of the quarterly MDS, dated [DATE], indicated Resident #81 had a BIMS score of 15 which indicated she was cognitively intact.Review of the physician's orders revealed an order for metformin HCl (antihyperglycemic agent) oral tablet 500 mg. Resident #81 was to take it by mouth twice a day for type 2 diabetes.Review of the State Agency's (SA) complaint portal revealed the facility made a self-report on December 2, 2025 at 4:36 P.M. Review of the facility's 5-day investigation report indicated that Staff #201 was observed, via security video, doing the counting (of medications) with the outgoing NOC (nocturnal) shift at the start of his 12-hour shift at 6:15 A.M. on November 29, 2025. The video revealed that around 5:00 P.M. Staff #201 was counting (medications) at the narcotic cart alone and removed a bottle with a red top indicating a narcotic. The report also noted that there was only one bottle of Oxycodone in the cart at the time which belonged to Resident #10. The report further noted that Staff #201 was observed taking the bottle down the hallway and returning to the hallway without the bottle. The video revealed him taking the narcotic sheet and putting it in his backpack and putting a bottle in his jacket, taking a pill, and putting another sheet and bottle in his backpack. The report indicated that both the Administrator/Staff #178 and Director of Nursing/Staff #52 contacted Staff #201 and requested that he return the narcotics to the facility. It also indicated that Staff #201 responded to both of them, verbally and via text messages, that he did not have the bottle of Oxycodone but he did send a picture, via text message, that he had taken another resident's (Resident #81) Metformin. The report explains the Staff #201 was then suspended on December 2, 2025 pending the outcome of the completed investigation. The facility reported the incident to the local police department and the police showed up to the facility on December 3, 2025 to investigate. It was noted that Staff #201 was booked into jail. On December 3, 2025 Staff #201 was terminated from the facility.An interview was conducted on December 10, 2025 at 8:31 A.M. with Licensed Practical Nurse (LPN/Staff #117). Staff #117 explained that controlled medications are kept in a lock box and when administering those medications, it is documented in the narcotic book the number of pills that are given. She added that they also sign their names next to the entry in the narcotic book. Staff #117 shared that it was not appropriate to take medications that you do not plan on administering because it would throw off the medication count and someone could get a hold of the medication and find themselves in a dangerous situation. Staff #117 indicated that diverting resident medications increases the risk of residents not receiving the medications they need or it might be given to the wrong resident who might not need the medication.An interview was conducted on December 10, 2025 at 8:42 A.M. with Registered Nurse (RN/Staff #49). She explained that medication diversion was not okay as it could be dangerous to those residents who might have allergies or drug addictions. She also added that it was not okay to take medications that you do not plan to administer to a resident.An interview was conducted on December 10, 2025 at 8:49 A.M. with LPN/Staff #16. Staff #16 explained that when medication is disposed of, a manager must be present as a witness. Staff further stated that if a second staff member is not present to witness the medication destruction, there is a risk the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035086	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sierra Vista, LLC	660 South Coronado Drive Sierra Vista, AZ 85635

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035086	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sierra Vista, LLC	660 South Coronado Drive Sierra Vista, AZ 85635

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of the facility's policies and procedures, the facility failed to ensure resident meals were served at appropriate temperatures. The sample size was five residents. The facility census was 88. The deficient practice could lead to residents receiving meals at unsafe temperatures which increases the risk of foodborne illnesses.Findings include:A complaint was received through the State Agency (SA) portal on November 25, 2025 at 2:37 pm alleging that food was served cold and was too spicy. Related to Resident #77-Resident #77 was admitted to the facility on [DATE] with diagnoses that includes pyothorax (infected pus pocket in the chest cavity) with fistula, pneumonia, and major depressive disorder. Review of the admission MDS, dated [DATE] revealed a BIMS score of 14 which indicated the resident is cognitively intact.An interview was conducted on December 7, 2025 with Resident #77 at 3:12 P.M. He shared that the food is cold and sometimes it was unidentifiable.Related to Resident #33-Resident #33 was admitted to the facility on [DATE] with diagnoses that includes chronic osteomyelitis (infection in the bloodstream) of the left ankle and foot, hypertension, and generalized muscle weakness.Review of the admission Minimum Data Set (MDS), dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact.An interview was conducted on December 7, 2025 at 3:25 P.M. with Resident #33. He stated that the food was always cold.Related to Resident #32-Resident #32 was admitted to the facility on [DATE] with diagnoses that includes a fracture to the left femur, a large blood clot in the fork of the main lung artery blocking blood flow to both lungs, and muscle weakness.Review of the admission Minimum Data Set (MDS), dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact.An interview was conducted on December 7, 2025 with Resident #32 at 3:51 P.M. He stated that the food is cold but it did taste better than his previous facility.Related to Resident #78-Resident #78 was admitted to the facility on [DATE] with diagnoses that includes pneumonia, acute kidney failure, and congestive heart failure.Review of the admission Minimum Data Set (MDS), dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact.An interview was conducted on December 7, 2025 at 4:00 P.M. He expressed that the food was not great in temperature, texture, and flavor.An observation of the lunch meal delivery was conducted on December 8, 2025 with Staff #32. During this observation, a temperature check of the test tray was conducted with Staff #32 at 1:21 P.M. using the facility's food thermometer. The temperature check of the test tray was conducted in the dining/activity room in hallway 300. The temperature of the roast beef was 111 degrees. The temperature of the mashed potatoes was at 123 degrees. The temperature of the mixed vegetables was at 142 degrees.An observation of the breakfast tray line was conducted on December 9, 2025 at 6:56 A.M in the kitchen. During this observation, a temperature check, using the facility's food thermometer, of the food on the steam table was conducted with Cook/Staff #19 and staff #32. The temperature of the sausage patties was 129 degrees. Staff #19 shared that the food sometimes gets cold on the steam table because the air conditioning duct was directly over the steam table. She was observed putting parchment paper over the sausage patties. At 7:19 A.M. a second temperature check of the sausage patties was taken and the temperature was 131 degrees.A second observation of the meal delivery was conducted on December 9, 2025 with Staff #32 at 7:50 A.M. During this observation, a temperature check of the test tray was conducted with Staff #32 at 8:11 A.M. using the facility's food thermometer. Staff #32 indicated the temperature of the grits was 141 degrees. The temperature of the biscuit was 96 degrees and the sausage was 96 degrees. Staff #32 shared that the temperatures were acceptable if the food was palatable.An interview was conducted with the Staff #19 on December 10 at 10:11 A.M. When asked about safe temperatures for food being served to residents, she explained that she thought that the food on the steam table needed to be 145 degrees or higher in order to be safe to serve. However, she did not know what temperatures the hot food needed to be when residents receive it. She also added that sometimes the food gets cold because it takes too long to get delivered to the residents. Staff #19 shared that it wasn't okay for residents to eat hot food cold because they would not be happy with it.An interview was conducted with Staff #32 on December 10, 2025 at 10:16 A.M. She indicated that the food that was being held on the steamer needed to be maintained at 135 degrees. However, she added that when hot food is being delivered to residents, they need to be at palatable temperatures and it would be dependent on the resident's preferences. She also explained that if residents feel that the food is